Los Alamos National Security, LLC

FLEXIBLE SPENDING ACCOUNT

LANL Group Number: 115976

Effective: January 1, 2010

FLEXIBLE SPENDING ACCOUNT PLANS

Notice to Employees

This booklet describes the Employer-sponsored Flexible Spending Account Plan ("Plan") as of January 1, 2010.

Los Alamos National Security, LLC has entered into an arrangement with Blue Cross/Blue Shield of New Mexico under which PayFlex Systems USA, Inc. will process reimbursements and provide certain other administrative services to the Plan.

PayFlex does not insure the benefits described in this booklet.

FSA PLAN HIGHLIGHTS

Under the Plan, you can elect to establish two Flexible Spending Accounts ("FSAs"). These accounts let you make before-tax contributions from your salary, which can then be used to reimburse yourself for Eligible Expenses.

The **Health Care Spending Account ("HCRA")** is for reimbursement of Eligible Health Care Expenses (defined in the **Health Care Spending Account** section); including certain medical and dental expenses for you, your spouse, your dependent children, and any other dependents you can claim on your federal tax return.

The **Dependent Care Spending Account ("DCRA")** is for reimbursement of Eligible Dependent Care Expenses (defined in the **Dependent Care Spending Account** section). The DCRA account is used to pay for eligible dependent care expenses that allow you and, if married, your spouse to work while your eligible dependents are being cared for. You can elect to participate in the HCRA, the DCRA, or both.

Each Plan year (January 1, 20XX through December 31, 20XX) you can contribute to your HCRA and DCRA, and then, during the Plan year, you can receive reimbursement from the appropriate account for Eligible Expenses that are not otherwise reimbursed. Contribution levels are set forth below.

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FSA ELIGIBILITY

1. When can I become a participant in the Plan?

You can participate in HCRA or DCRA if you meet at least one of the following requirements:

- You are an active LANS employee appointed to work at least 50% time for one year or more, or 100% time for three months or more;
- You are an active LANS employee who has worked 1,000 hours in 12 months; or
- You are appointed to work at least 43.75% time.

Before you become a Plan member (referred to in this Summary Plan Description (SPD) as a "Participant"), there are certain rules which you must satisfy. First, you must meet the eligibility requirements. There are three instances which opens a Life Event, thus the opportunity to enroll in the Plan.

1. Newly employed by LANL. You may enroll during your Period of Initial Eligibility (PIE) , which begins the first day of LANL employment and ends 31 days later; or
2. Benefits Open Enrollment. During LANL's annual Benefits Open Enrollment you may enroll on-line through the Oracle Self-Service On-Line Application; or
3. Change in family or employment status. You have 31 days from the date of the qualifying event to enroll in or change your FSA election.

Please refer to the LANS Health & Welfare Benefit Plan for Employees SPD for detailed eligibility requirements.

2. What must I do to enroll in the Plan?

Before you can participate in the Plan, you must complete then submit an enrollment form to the LANL Benefits Office. The completed enrollment form reflects your elections for the HCRA and/or DCRA accounts. The Benefits Enrollment form is located on the LANL Benefits website.

II
CONTRIBUTIONS

1. How much of my pay may I contribute to the HCRA and DCRA accounts?

For both HCRA and DCRA you may contribute a minimum of $180 to a maximum of $5,000 on a pre-tax basis per plan year, per plan. If both you and your spouse are LANS employees, you may each contribute up to $5,000 to your HCRA. Your contributions for your HCRA and/or DCRA are taken semi-monthly on a pretax basis in equal increments. DCRA contribution amounts are determined by the Federal Government for each Plan year. If you are married and filing separately for federal tax purposes the maximum amount you can contribute to your DCRA is $2,500. If you are married and filing jointly or single filing as Head of Household

for federal tax purposes the maximum amount you can contribute to your DCRA is $5,000. The contribution amounts are expected to change for each plan year. Please confirm with the LANL Benefits Office the total amount(s) you may contribute to each the HCRA and DCRA.

2. Can the amounts allocated toward the HCRA be used for the DCRA, and vice-versa?

Amounts allocated to one account cannot be used to reimburse expenses accrued in another account. You should carefully estimate your expected expenses because allocations can not be transferred into a different account, and IRS regulations require that you forfeit any unused funds remaining in either account after the end of the Plan year. You have until March 15 of the plan year (Plan) following the year you enroll to incur eligible expenses and until June 15 to submit reimbursement requests to PayFlex.

3. When must I decide the amount of money I want to contribute per program?

You are required by Federal law to decide before the Plan Year begins or within the 31 days of your Life Event (PIE). IRS regulations do not permit you to stop or change the amount you contribute to a flexible spending account during the Plan year, unless you experience a Qualified Change in Status.

4. May I change my elections during the Plan Year?

The below rules are intended to be consistent with the IRS regulations under Section 125 of the Internal Revenue Code, and to the extent there is any inconsistency, those regulations shall control.

Generally, you cannot change the elections you have made after you have made your initial election amounts for that Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "qualifying change in status" and you make an election change that is consistent with the change in status. A list of qualifying events is located on the LANL Benefits website and within the LANS Health & Welfare Benefit Plan for Employees SPD

In addition to LANL's standard qualifying life events, HRCA participants will experience a qualifying life event (thus begin a 31 day PIE) when the following occur:

- You become entitled to Medicare or Medicaid; you may elect to revoke your HCRA coverage.
- If the FSA Plan Sponsor receives a judgment, decree or order resulting from your divorce, legal separation, annulment or change in legal custody that requires group health coverage for your dependent child then the FSA Plan Administrator may:

  If the order requires you to provide coverage for the child under the HCRA, change your election to provide coverage for that child.

  If the order requires your former spouse to provide coverage, permit you to cancel your child's coverage under the HCRA.

In addition to the LANL's standard qualifying life events, DCRA participants will experience a qualifying life event (thus begin the 31 day PIE) when the following occur:

- A change in your dependent care provider.

- Your dependent care provider significantly increases or decreases the cost of the dependent care, but only if the dependent care provider that imposes the cost change is not related to you.
- An event that results in a change in work site.
- A change in the place of residence of you, your spouse, or dependent, as allowed by IRS regulations.

5. May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, we will consider that to mean you have elected not to participate for the upcoming Plan Year.

III
Flexible Spending Account BENEFITS

1. What benefits are available?

Health Care Reimbursement Account (HCRA):

The Health Care Reimbursement Account enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by your medical plan and save taxes at the same time. IRS Publication 502 – Medical and Dental Expenses is also available as a guide, but is not always the rule for eligible expenses under Flexible Spending Accounts. Drug costs, including some "over-the-counter" drugs and medicines may be reimbursed. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of reimbursable expenses is available from the Payflex website, https://lans.payflex.com; also see IRS Publication 502, www.irs.gov

The most that you can contribute to your Health Flexible Spending Account each Plan Year is $5,000 (but not less than $180). The HCRA allows you to be reimbursed monies allocated in your FSA account for out-of-pocket medical, dental and/or vision expenses incurred by you and your eligible dependents. Any reimbursement you receive through your HCRA can not be reimbursed under any other plan covering health benefits, including your spouse's plan.

LANL participants have been provided a credit/debit card to use to pay for medical expenses, such as co-pays, deductibles, medical equipment and drug costs. When you use the card for purchasing healthcare related items, your healthcare account is automatically debited to pay for eligible expenses. You can use the card at qualifying merchant locations that have implemented an Inventory Information Approval System (IIAS) and accept MasterCard®. This includes places such as physician and dental offices, pharmacies and vision providers. Further information on the PayFlex debit card can be found at: https://lans.payflex.com.

Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month. Expenses

under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care. PayFlex requires certain cost documentation in order to process your reimbursement. In many cases you will be required to provide to PayFlex an Explanation of Benefits (EOB) from the service provider. Only expenses which are incurred while you are a participant in the Plan may be reimbursed from a Flexible Spending Account. In addition, expenses which are incurred during one Plan Year cannot be reimbursed from funds contributed to your HCRA during another Plan Year. An expense is considered incurred when services are provided, not when you are billed or when you pay for care. However, LANL currently (CY2010) allows for participants to have until March 15 of the Plan Year (Plan) following the year you enroll to incur eligible expenses and until June 15 to submit reimbursement requests to PayFlex.

Dependent Care Reimbursement Account (DCRA):

DCRA enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account to reimburse day-care expenses.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

(a) A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws:

(b) An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible;

(c) An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes, and

(d) A dependent who lives with you—such as a child age 13 or older, parent, sibling, or in-law—who is incapable of self-care, and whom you claim as a dependent on your tax return. If care is provided outside of your home for a spouse or a dependent age 13 or older, either of whom is incapable of self-care, the spouse or dependent must live in your home at least eight hours each day.

You should make sure that the dependent care expenses you are currently paying for qualify under the Plan.

The law places limits on the amount of money that can be paid to you in a Plan year from your DCRA. Generally, your reimbursements may not exceed the lesser of: (a) $5,000 (if you are

married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of $250 for one dependent or $500 for two or more dependents). You must contribute a minimum of $180.

Dependent day care claims may be submitted when the service is provided. If the expense has been incurred and proper documentation has been provided (legible receipts with all necessary fields), the claim is ready to be processed against the participant's accounts. You can find claim forms at https://lans.payflex.com via the Forms link. Claims should be submitted following the completed dates of service. Your account balance is checked to determine how much is available for reimbursement. If the amount of the claim is less than your available balance, then the entire claim can be reimbursed. If the amount of the claim is greater than your available balance, you will only be reimbursed the amount that is available in your dependent day care account.

In order to have the reimbursements made to you, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred.

The PayFlex Card:

The PayFlex Card is for use with your HCRA, not your DCRA. When you use your PayFlex Card, funds are automatically deducted at the point-of-sale from your healthcare spending account to pay for eligible expenses. Please remember, the PayFlex Card will only be accepted at healthcare related merchants AND merchants who have implemented an Inventory Information Approval System (IIAS). To view a listing of merchants and that have implemented or will be implementing this system, go to https://lans.payflex.com.

PayFlex Card information:

(a) Your card will be activated when first used.

(b) Make sure you select "credit" when using your card.

(c) In order for your PayFlex Card to work, the merchant must accept MasterCard.

(d) The card can only be used at healthcare related merchants AND merchants who have implemented an Inventory Information Approval System (IIAS).

(e) You may use the card to pay for eligible FSA healthcare items or services up to the annual election amount regardless of how much you have contributed to the account.

(f) SAVE your itemized receipts and Explanation of Benefits (EOB) from the insurance company. An itemized receipt must include; date of purchase, description of purchase, true and final amount of purchase, name of merchant and name of the person receiving the service.

IV
Flexible Spending Account BENEFIT PAYMENTS

1. When will I receive reimbursements from my HCRA and/or DCRA?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. PayFlex will provide access to acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. You will only be reimbursed from the Dependent Care Reimbursement Account (DCRA) to the extent that there are sufficient funds in your Account to cover your claim.

2. What happens if I don't spend all Plan contributions during the Plan Year?

If you have not spent all the amounts in your HCRA or DCRA by the end of the Plan Year, you may continue to incur claims for expenses during the "Grace Period." The "Grace Period" extends 2 1/2 months after the end of the Plan Year, during which time you can continue to incur claims and use up all amounts remaining in your FSA.

Any monies left at the end of the Plan Year and the Grace Period will be forfeited. Qualifying expenses that you incur late in the Plan Year or during the Grace Period for which you seek reimbursement after the end of such Plan Year and Grace Period will be paid first before any amount is forfeited. For the HCRA, you must submit claims no later than 195 days after the end of the Plan Year. For the DCRA, you must submit claims no later than 195 days after the end of the Plan Year.

3. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for the HCRA. If your coverage in HCRA terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year within 31 days of our return to work, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make catch-up payments for the time that you are on leave. For example, if you elect $1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference - from $100 per month to $150 per month. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect $1,200 for the year and are out on leave for 3 months, your amount will be reduced to $900. The expenses you incur during the time you are not actively participating in HCRA are not reimbursable. DCRA coverage ends on the last day of the month following the date of termination or leave.

4. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your FSA under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. More information on how USERRA may affect your FSA benefits is located in the LANS Health & Welfare Benefit Plan for Employees SPD, the DOL website, or contact the LANL Benefits Office.

5. What happens if I terminate employment?

Please see the LANS Health & Welfare Benefit Plan for Employees SPD, section “When Coverage Ends”.

(a) DCRA: You will still be able to request reimbursement for qualifying dependent care expenses (DCRA) for the remainder of the Plan Year from the balance remaining in your dependent care account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate. You must submit DCRA claims within 195 days after the end of the Plan Year in which termination occurs.

(b) HCRA: Upon your termination of employment, your participation in the Health Flexible Spending Account (HCRA) will cease, and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses that were incurred before the end of the period for which payments to the HCRA have already been made. Your further participation will be governed by "Continuation Coverage Rights under COBRA."

6. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

V
GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

1. General Plan Information

LANS Flexible Spending Account is the name of the Plan.

LANS has assigned Plan Number 501 to your Plan.

The provisions of your Plan become effective on January 1, 2010.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

2. Plan Sponsor and Administrator

The name, address, identification number and business telephone number of your Employer/Plan Sponsor/Administrator

LANS (Los Alamos National Security, LLC)
P.O. Box 1663, MS P280
Los Alamos, New Mexico 87545
20-3104541
505-667-1806 or 1-800-667-1806

3. Claims Administrator

PayFlex Systems USA, Inc.

The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Sponsor through an administrative agreement with the Claims Administrator. The Claims Administrator processes the Plan reimbursement requests, determines if expense is eligible and if the documentation for the claims is acceptable, reviews and makes determination relating to claims appeals, and provides customer service for Plan members.

Claims for expenses should be submitted to:

PayFlex Systems USA, Inc.
P.O. Box 3039
Omaha, NE 68103-3039
800-284-4885 ph
402-231-4310 fax

VI
ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA

Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

(a) Examine, without charge, at the Administrator's office, all Plan documents, including pertinent insurance contracts, trust agreements, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan

with the Internal Revenue Service or the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration;

(b) Obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies;

(c) Continue health coverage for a Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage; and

(d) Review this summary plan description and the documents governing the plan on the rules governing COBRA continuation rights.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan Participants.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA) or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

2. Claims Process

You should submit all reimbursement claims during the Plan Year. For the Health Flexible Spending Account, you must submit claims no later than 195 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, you must submit claims no later than 195 days after the end of the Plan Year. Any claims submitted after that time will not be considered.

If a dependent care claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the denial to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

In the case of a claim for medical expenses under the Health Flexible Spending Account, the following timetable for claims applies:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the claim:	
Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

(a) The specific reason or reasons for the denial;

(b) Reference to the specific Plan provisions on which the denial was based;

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial on review;

(e) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and

(f) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

(a) Was relied upon in making the claim determination;

(b) Was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(c) Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(d) Constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

3. Qualified Medical Child Support Order

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

VII
CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under health benefits under this Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA. While the Plan itself is not a group health plan, it does provide health benefits. Whenever "Plan" is used in this section, it means any of the health benefits under this Plan including the Health Flexible Spending Account.